CONSENT for ELECTIVE ABORTION

PLEASE
INITIAL

____ **1.** **I, ______________________________________, AGE:** _____ hereby consent to the performance upon me of an **abortion** procedure by suction "D & C" using a local anesthetic ("Paracervical Block") by Herbert C. Hodes, M.D., or Traci L. Nauser, M.D. The procedure is being done at **MY** request; and with **MY** consent, which **I** give freely. Intravenous drugs may also be given, and I have signed this permit **BEFORE** receiving any such drugs

____ **2.** **I** further **consent** to the performance of **any** additional emergency procedures, which may be indicated because of unforeseen conditions arising during this abortion procedure.

____ **3.** **I** have disclosed to the doctor my **complete** medical history: including **ALLERGIES**, adverse reactions to any medications or anesthetics**;** **ANY** previous surgery, abortions, or procedures on my cervix; as well as telling the doctor about **ANY medications or drugs** that **I** have taken since my last menstrual period.

____ **4.** **I** believe I'm less than **22** weeks pregnant. My **LAST MENSTRUAL PERIOD BEGAN** on: _____/_____/_____
My period: was / was NOT normal (circle one).

____ **5.** **I** understand there are very few complications from abortions, and certainly less than from a full-term delivery. **Any** surgical procedure involves risks of complications that could occur **without** the fault of Dr. Hodes or Dr. Nauser.

____ **6.** **SOME of the *possible* complications** of abortions are the following**:**

	Complication	Rate
a.	Retained blood clots or tissue requiring repeat suction, or a "D & C"	< 1: 100
b.	Hemorrhage (Excessive bleeding), or Infection	< 1: 500
c.	Missing an Ectopic ("Tubal") pregnancy (pregnancy outside of the uterus)	< 1: 500
d.	"Missing" an early pregnancy (and still being pregnant)	< 1: 1,000
e.	Failure of the blood-clotting mechanism (**disseminated intravascular coagulopathy, "D.I.C."**) with need for extensive blood transfusion replacement	< 1: 1,000
f.	Uterine Perforation, with damage to other organs (bladder, intestines); Hospitalization; Major Surgery; Hysterectomy; or Sterility (inability to get pregnant)	< 1: 10,000
g.	Toxic Shock, Death	< 1: 250,000

____ **7.** **I realize** that such complications can be caused by my own medical condition, my behavior after the procedure, by the treatment of follow-up physicians; **OR** may occur spontaneously without the fault of **any** person.

____ **8.** **IF** I have any problems after the abortion, **I** will immediately notify one of the above doctors as explained in the ***Abortion Aftercare Instructions***. **I** understand that my failure to promptly notify the doctor may lead to delay of proper treatment and could cause further complications. **I** understand that if **I** seek any alternate treatment without the prior instruction of one of the doctors to do so, I may **not** hold either doctor responsible for subsequent medical expenses, **or** any other loss experienced as a result thereof.

____ **9.** **I** agree to have a Post-Abortion Exam in **1 (one)** to **4 (four)** weeks; and that failure to do so shall release the doctors from **all** medical, legal, or financial responsibility for **any** abortion-related problems that might arise at a later date.

____ **10.** I agree **NOT** to drive **OR** make important decisions for 24 hours if I have received intravenous sedation.

____ **11.** **I** acknowledge that it is **MY** responsibility to ask the doctor **any** questions that **I** have pertaining to the abortion; **OR** to this consent form, **before** I sign it below.

I certify that I have read this form, initialed it; and that I fully understand its contents.

SIGNED: ____ ***DATE:*** _____ / _____ / ______

© H.C .Hodes, MD 2009